STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G715	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTOLE INC	523 PARK LANE NASHVILLE, IN47448

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for a post certification revisit (PCR) to the investigation of complaint #IN00092814 completed on July 11, 2011 where unrelated deficiencies were cited. Dates of Survey: September 1 and 2, 2011. Facility number: 004000 Provider Number: 15G715 AIM Number: 200481990 Surveyor: Steven Schwing, Medical Surveyor III These deficiencies also reflect state findings in accordance with 431 IAC 1.1.	W0000		
W0104	The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 1 of 3 clients in the sample (C), the governing body failed to exercise operating direction over the facility by failing to ensure a hole in client C's bedroom wall was repaired timely. Findings include: An observation was conducted at the group home on 9/1/11 from 2:39 PM to 4:01 PM. At 2:51 PM, a 3 inch by 4 inch hole was observed in client C's bedroom wall above her headboard. An interview with Direct Care Staff (DCS) #1 was conducted on 9/1/11 at 2:41 PM. DCS #1 stated the hole had been present for "several months." He indicated Administrative staff (AS) #1 completed a maintenance request to fix the hole. On 9/1/11 at 2:58 PM, a review of the facility's Maintenance/Repair Request Forms was	W0104	W 104Christole is committed to supporting a governing body that exercises general policy, budget and operating direction over the facility to operate in substantial compliance with State and Federal regulatory requirements.The Maintenance Supervisor will ensure that the following area is repaired: A 3x4 inch hole in client C's bedroom wall.The repairs will be completed by September 30, 2011. Documentation of repair will be available at the Central office. The Program Director (PD) will train QDDP's and CLM's, and ACLM's on submitting maintenance requests. The Parklane QDDP or CLM will provide training on submitting Maintenance requests to group	09/30/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	conducted. There was no maintenance request to repair the hole in client C's wall. An interview with AS #1 was conducted on 9/1/11 at 2:59 PM. AS #1 indicated he did not complete a work order for the hole in client C's bedroom wall. This deficiency was cited on 7/11/11. The facility failed to implement a systemic plan of correction to prevent recurrence.		home staff. Both trainings will be completed by September 30, 2011. Copies of the training signature sheets will be available at the Central office.	
W0149	1.1-3-1(a) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 4 of 6 clients living in the group home (A, B, E and F), the facility neglected to implement its policies and procedures to prevent abuse and neglect of the clients. Findings include: A review of the facility's incident/investigative reports was conducted on 9/1/11 at 1:01 PM. -On 8/22/11 at 7:15 PM, client A pinched client F on the neck. The investigative report indicated there was a "mark" on client F's neck. The facility substantiated abuse with intent to cause abuse/harm/injury. -On 8/21/11 at 4:30 PM, client B hit a peer (the report did not indicate who) "lightly" on the arm and on the back of her head. -On 7/28/11 at 5:15 PM, client A bit client B on the chest causing a red mark. The facility substantiated abuse without intent to cause harm. -On 7/20/11 at 1:00 PM, staff #7 asked staff #2 and #8 if client E had been checked. Staff #2, according to staff #7 and #8, went into client E's room to check on him. Staff #2 came back out of	W0149	W149Christole is dedicated in maintaining a policy and environment that prohibits the mistreatment, neglect, or abuse of the individual's served.Training on the prevention of abuse and neglect has been added to the New Employee Orientation. The Quality Improvement Director (QID) will revise the Abuse and Neglect Training Module to include specific training on staff monitoring peer interaction and proximity. The QID will train QDDP's, CLM's, ACLM's and Program Directors (PD) on the revision by September 30, 2011. The Program Director (PD) will train Parklane group home staff on the revision by September 30, 2011. A copy of the Abuse and Neglect Training Module revision and copies of both training signature sheets will be available at the Central office.	09/30/2011

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	client E's room and indicated client E was fine. Staff #7 went into client E's room 2 minutes later and client E had been incontinent of urine and feces. Staff #7 indicated client E's room smelled of urine. Staff #7 reported the feces was stuck and dried. Staff #7 indicated she considered staff #2 to be negligent. Staff #8 indicated she considered staff #2 to be negligent in his duties. The investigative report indicated an interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 7/26/11. The QMRP indicated in her statement she was informed of the incident on 7/21/11. The QMRP indicated she did not report the incident to anyone. Her statement indicated the following, "...I wasn't sure how to go about it." The investigative report did not address the QMRP's statement that she was not sure how to report neglect. A review of the facility's Investigative Incident Report Process, dated 8/29/11, was conducted on 9/1/11 at 2:17 PM. The policy indicated the following, "People receiving services must not be subjected to abuse by anyone, including, but not limited to, facility staff, peers, consultants or volunteers, family members, friends or other individuals." The policy indicated, "Any individual who has reason to believe that a child or adult is a victim of abuse or neglect must make a report... A person who has reason to believe that a child or adult is a victim of abuse or neglect must immediately page/call an Administrator with an oral report to be followed up with a written report within 24 hours." The policy defined neglect as, "failure of staff to provide goods or services necessary to avoid physical or psychological harm." An interview with the Director of Residential Services (DRS) was conducted on 9/1/11 at 2:12			

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	PM. The DRS indicated the facility prohibits abuse and neglect of the clients. This deficiency was cited on 7/11/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			
W0153	1.1-3-2(a) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 13 incident/investigative reports reviewed afffecting clients B and E, the facility failed to ensure the administrator was immediately notified of neglect and BDDS (Bureau of Developmental Disabilities Services) was notified of reportable incidents within 24 hours, in accordance with state law. Findings include: A review of the facility's incident/investigative reports was conducted on 9/1/11 at 1:01 PM. -On 8/21/11 at 4:30 PM (reported to BDDS on 8/23/11), client B hit a peer (the report did not indicate who) "lightly" on the arm and on the back of her head. There was no BDDS report for the person who was hit. -On 7/20/11 at 1:00 PM (reported to BDDS on 7/25/11 and administrative staff became aware on 7/25/11), staff #7 asked staff #2 and #8 if client E had been checked. Staff #2, according to staff #7 and #8, went into client E's room to check on him. Staff #2 came back out of client E's room and indicated client E was fine. Staff #7 went into client E's room 2 minutes later and client E had been incontinent of urine and feces. Staff #7 indicated client E's room smelled of urine. Staff #7 reported the feces was stuck and dried. Staff #7 indicated she considered staff #2 to be negligent. Staff #8 indicated she considered staff #2 to be negligent in his duties. An interview with the Director of Residential Services	W0153	W 153 Christole is committed to supporting a governing body that exercises general policy, budget and operating direction over the facility to operate in substantial compliance with State and Federal regulatory requirements. The Quality Improvement Director (QID) will create a BDDS Reportable acknowledgement form. The group home staff will be required to sign off on form daily to ensure all incidents have been reported. The form will need to be completed each shift to ensure staff awareness of reporting of the BDDS Reportable items. The QID will train QDDP's, CLM's, ACLM's, and Program Directors (PD) on the use of the form by September 30, 2011. The Program Director (PD) or QDDP will train the Parklane group home staff on the acknowledgement form by September 30, 2011. A copy of the acknowledgement form and both training signature sheets will be available at the Central office.	09/30/2011

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	(DRS) was conducted on 9/1/11 at 2:12 PM. The DRS indicated the facility should report to BDDS within 24 hours. This deficiency was cited on 7/11/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 1.1-3-1(b)(5) 1.1-3-2(a)			
W0154	The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 13 incident/investigative reports reviewed affecting client B, the facility failed to ensure a thorough investigation was conducted into abuse/neglect. Findings include: A review of the facility's incident/investigative reports was conducted on 9/1/11 at 1:01 PM. On 8/21/11 at 4:30 PM, client B hit a peer (the report did not indicate who) "lightly" on the arm and on the back of her head. There was no investigation presented during the survey for review. An email, reviewed on 9/2/11 at 11:37 AM, from the Director of Quality Improvement, dated 9/2/11 at 11:37 AM, indicated an investigation was not conducted for this incident. An email reviewed on 9/2/11 at 12:29 PM from the Director of Quality Improvement, dated 9/2/11 at 12:29 PM, indicated an investigation should have been conducted. This deficiency was cited on 7/11/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 1.1-3-2(a)	W0154	W 154 Christole is committed to supporting a governing body that exercises general policy, budget and operating direction over the facility to operate in substantial compliance with State and Federal regulatory requirements. The Quality Improvement Director (QID) will create a BDDS Reportable acknowledgement form. The group home staff will be required to sign off on form daily to ensure all incidents have been reported. This will include immediately reporting any incidents of suspected abuse and neglect. The QID will train QDDP's, CLM's, ACLM's and PD's on the BDDS Reportable acknowledgement form. This training will be completed by September 30, 2011. The PD or QDDP will train the Parklane group home staff on the BDDS acknowledgement form by September 30, 2011. A copy of the form and both training signature sheets will be available at the Central office.	09/30/2011

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W0157	If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 13 incident/investigative reports reviewed affecting client E, the facility failed to ensure appropriate corrective action was taken. Findings include: A review of the facility's incident/investigative reports was conducted on 9/1/11 at 1:01 PM. On 7/20/11 at 1:00 PM, staff #7 asked staff #2 and #8 if client E had been checked. Staff #2, according to staff #7 and #8, went into client E's room to check on him. Staff #2 came back out of client E's room and indicated client E was fine. Staff #7 went into client E's room 2 minutes later and client E had been incontinent of urine and feces. Staff #7 indicated client E's room smelled of urine. Staff #7 reported the feces was stuck and dried. Staff #7 indicated she considered staff #2 to be negligent. Staff #8 indicated she considered staff #2 to be negligent in his duties. There was no disciplinary action taken with staff #2. The investigative packet contained two faxed Concerns/Issues Tracking Sheets, fax dated on 7/20/11 at 1:43 PM and 1:44 PM. The report did not include corrective action to address the issue. -Staff #7 documented on her report, dated 7/20/11, the following, "[Staff #2] was asked to check on [client E] to see if he needed changed since it was an hour after lunch. He went in and came back out quickly, stating, "he's fine." I went in about two minutes later and smelled urine so I checked [client E] and his bed was soaked and he had dried feces in his pull-up. [Staff #8] came in to check on me to see why I had entered and she witnessed this as well. She is the one who changed the soaked bed clothes while I had to clean the dried feces and changed [client E]. We know it was not a recent accident because the entire bed was soaked and the feces were (sic) dried all around the sacral (sic) area." -Staff #8 documented on her report, dated 7/20/11, the following, "[Staff #2] was asked if [client E] had been checked. He said he would check on [client E]. He went in and came back out quickly and stated that he was fine. [Staff #7] went in about 2 minutes later	W0157	W 157 Christole is committed to supporting a governing body that exercises general policy, budget and operating direction over the facility to operate in substantial compliance with State and Federal regulatory requirements. Christole has implemented Client Assignment sheets to ensure staff accountability to Individual assignments. This process also holds staff accountable for appropriate care of assigned individuals. Training on the client assignments process for PD's, QDDP's, CLM's and ACLM's was completed on August 24, 2011. Training for Parklane group home staff was completed on July 6 and July 28, 2011. Copies of both training signature sheets will be available at the Central Office. This process also allows Christole Administrative staff to monitor for any neglectful behavior and provide corrective action as appropriate.	09/30/2011

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	and smelled urine. That's when [staff #7] went in to check on [staff #8] and saw what happened. [Staff #8] was the one to change the soaked bed clothes while [staff #7] cleaned [client E] and changed him. [Staff #7 and #8] knew it was a recent accident because the bed was soaked and the feces was dried all around sacral (sic) area." An interview with the Director of Residential Services (DRS) on 9/1/11 at 2:12 PM. The DRS indicated the investigative report should have addressed corrective action taken. The DRS indicated corrective action should have been taken with staff #2.			
W0210	1.1-3-2(a) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, record review and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to ensure the clients' abilities to regulate water temperature was assessed. Findings include: On 9/1/11 at 2:58 PM, a review of the facility's Maintenance/Repair Request Forms was conducted. A form, dated 9/1/11, indicated the following: kitchen sink temperature was 112 degrees F, bathroom sink by laundry room was 124 degrees F, bathroom #2 was 114 degrees F (did not indicate what was tested), and bathroom #2 was 115 degrees F (did not indicate what was tested). An observation was conducted at the group home on 9/1/11 from 2:39 PM to 4:01 PM. At 2:58 PM, Administrative Staff (AS) #1 indicated he had not	W0210	W 210 Christole is committed to performing accurate assessments or reassessments as needed. The Quality Improvement Director (QID) will revise the Functional Assessment to include “Does the individual show the ability to regulate and mix hot and cold water temperature?” The QID will train PD’s, QDDP’s, CLM’ s, and ACLM’s on the revised form by September 30, 2011. The QDDP will complete the revised section of the assessment on each individual as needed. A copy of the revised Functional Assessment and training signature sheet will be available at the Central Office.	09/30/2011

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	tested the showers/tubs when testing the water temperatures. At 2:59 PM, AS #1 retested the temperatures in the bathroom near the laundry room. The sink was 124 degrees F and the shower was 120 degrees F. A review of client A's Functional Assessment (FA) was conducted on 9/2/11 at 10:57 AM. The FA, dated 3/8/10, did not assess whether or not client A could safely regulate water temperature. A review of client B's FA was conducted on 9/2/11 at 10:58 AM. The FA, dated 3/8/10, did not assess whether or not client B could safely regulate water temperature. A review of client C's FA was conducted on 9/2/11 at 10:59 AM. The FA, dated 5/17/11, did not assess whether or not client C could safely regulate water temperature. A review of client D's FA was conducted on 9/2/11 at 11:00 AM. The FA, dated 2/7/11, did not assess whether or not client D could safely regulate water temperature. A review of client E's FA was conducted on 9/2/11 at 11:01 AM. The FA, dated 5/19/11, did not assess whether or not client E could safely regulate water temperature. A review of client F's FA was conducted on 9/2/11 at 11:02 AM. The FA, dated 2/14/11, did not assess whether or not client F could safely regulate water temperature. An interview with Administrative staff (AS) #1 was conducted on 9/2/11 at 9:47 AM. AS #1 indicated he was unsure if the clients were able to safely regulate their water temperatures.			

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	An interview with the Director of Residential Services (DRS) was conducted on 9/2/11 at 12:01 PM. The DRS indicated the clients should be assessed for their ability to safely regulare water temperatures. 1.1-3-7(a)			
W0249	As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.			
	Based on observation, interview and record review for 1 of 3 clients in the sample (C), the facility failed to ensure her program plan for the use of a snack box was implemented as written. Findings include: An observation was conducted at the group home on 9/1/11 from 2:39 PM to 4:01 PM. At 2:41 PM, client C's snack box was observed sitting on the kitchen counter. The box contained 2 packages of crackers, 2 boxes of raisins, 2 fruit and grain bars and 1 apple. Client C returned home from school at 3:00 PM. At 3:56 PM, client C got a package of crackers from her snack box. An interview with Direct Care Staff (DCS) #2 was conducted on 9/1/11 at 2:41 PM. DCS #2 indicated client C could eat whatever she wanted from her snack box; he indicated there was no limit. A review of client C's Snack Box Procedure, dated 5/26/10, was conducted on 9/1/11 at 2:55 PM. The procedure indicated the following: "2. On	W0249	W 249 Christole is committed to ensuring appropriate implementation of programs. Christole will implement a process to assess knowledge on Individual program plans. This process will be completed on a monthly basis by the QDDP to ensure that the written plans are being followed as written. The Quality Improvement Director (QID) will train all QDDP's on the guidelines of the written process. This training will be completed by September 30, 2011. The QDDP will inform the Parklane group home staff about the guidelines of the written process by September 30, 2011. The QDDP will submit monthly verification of relevant training for staff participation on individual's written plans. Copies of both training signature sheets will be available at the Central office.	09/30/2011

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	days that [client C] has school she will select, with staff assistance, 3 low calorie snacks for her snack box..." An interview with the Director of Residential Services (DRS) was conducted on 9/2/11 at 12:01 PM. The DRS indicated the staff should implement client C's snack box protocol as written. This deficiency was cited on 7/11/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			
W0426	1.1-3-4(a) The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. Based on observation, record review and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F), the facility failed to ensure the water temperature did not exceed 110 degrees Fahrenheit (F). Findings include: On 9/1/11 at 2:58 PM, a review of the facility's Maintenance/Repair Request Forms was conducted. A form, dated 9/1/11, indicated the following: kitchen sink temperature was 112 degrees F, bathroom sink by laundry room was 124 degrees F, bathroom #2 was 114 degrees F (did not indicate what was tested), and bathroom #2 was 115 degrees F (did not indicate what was tested). An observation was conducted at the group home on 9/1/11 from 2:39 PM to 4:01 PM. At 2:58 PM, Administrative Staff (AS) #1 indicated he had not tested the showers/tubs when testing the water	W0426	W 426 Christole is committed to ensuring that all environmental guidelines are met. Christole conducts monthly environmental checks including water temperature. In the absence/change in the CLM management in the group home, the Program Director (PD) will complete the monthly checks and ensure that monthly documentation is completed until the CLM position is filled to ensure appropriate environmental safety.	09/30/2011

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	temperatures. At 2:59 PM, AS #1 retested the temperatures in the bathroom near the laundry room. The sink was 124 degrees F and the shower was 120 degrees F. A review of client A's Functional Assessment (FA) was conducted on 9/2/11 at 10:57 AM. The FA, dated 3/8/10, did not assess whether or not client A could safely regulate water temperature. A review of client B's FA was conducted on 9/2/11 at 10:58 AM. The FA, dated 3/8/10, did not assess whether or not client B could safely regulate water temperature. A review of client C's FA was conducted on 9/2/11 at 10:59 AM. The FA, dated 5/17/11, did not assess whether or not client C could safely regulate water temperature. A review of client D's FA was conducted on 9/2/11 at 11:00 AM. The FA, dated 2/7/11, did not assess whether or not client D could safely regulate water temperature. A review of client E's FA was conducted on 9/2/11 at 11:01 AM. The FA, dated 5/19/11, did not assess whether or not client E could safely regulate water temperature. A review of client F's FA was conducted on 9/2/11 at 11:02 AM. The FA, dated 2/14/11, did not assess whether or not client F could safely regulate water temperature. An interview with Administrative staff (AS) #1 was conducted on 9/2/11 at 9:47 AM. AS #1 indicated he was unsure if the clients were able to safely regulate their water temperatures.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G715	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	An interview with the Director of Residential Services (DRS) was conducted on 9/2/11 at 12:01 PM. The DRS indicated the water should be within the guidelines. 1.1-3-7(a)			